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Pricing Framework for Australian Public Hospital Services 2024-25

AMA submission to IHACPA Consultation Paper

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The AMA appreciates the opportunity to submit to this consultation, as we have done every year since IHACPA started consulting on the pricing framework.

The AMA is the peak professional body representing medical practitioners in Australia, focused on promoting and protecting the professional interests of doctors and the healthcare needs of patients and communities. AMA members are reporting that the funding for Australia's hospitals is inadequate. This results in poorer outcomes for people presenting at Australia's hospitals and in negative outcomes for medical professionals, particularly medical trainees, who are increasingly burnt out, actively considering leaving the profession or are indeed leaving the profession.[1]

As outlined in many of our previous submissions to the IHACPA pricing framework consultations, the AMA is concerned that the current funding model does not adequately reflect or compensate for growing complexities of the health needs of our ageing population and the growing burden of disease in Australia. All of this has only been amplified by the impact of the COVID-19 pandemic.

Furthermore, we are increasingly noticing that the pricing framework yearly consultations fail to appropriately take into consideration the views of external stakeholders, particularly medical professionals who are bearing the brunt of the deteriorating performance of our public hospitals through being overworked and by frequently being either verbally abused or physically attacked by dissatisfied patients. While the stakeholder input is acknowledged when the yearly National Efficient Price (NEP) Determination is published, it is becoming increasingly obvious that the NEP determination year on year functions as a cost saving exercise rather than an actual reflection of the public hospital funding needs.

The AMA submission will address several proposals outlined in the proposed Pricing Framework 2024-25 that are of greatest concern to our members.

[1] https://www.medicaltrainingsurvey.gov.au/Download/2022/2022-Medical-Training-Survey-National-Report.pdf

Classifications used to describe and price public hospital services

Non-admitted care

The AMA supports the continuation of Tier 2 to price non-admitted services, in particular Long COVID. We also welcome IHACPA's further work on investigating refinements to Tier 2 to capture the activity delivered by innovative models of care. The AMA believes this is important because activities that are innovative and proven to work should continue to be funded through regular public hospital funding frameworks, as opposed to just being funded by the states or individual hospitals.

The AMA also welcomes the commencement the Australian Non-Admitted Patient Classification Project that aims to utilise health information within the jurisdictional electronic medical record systems to develop a new non-admitted care classification. The AMA has consistently argued that the appropriate use of health data (that is already available in the eMr systems) can provide an evidence base for planning of care and services, both at the practice level and across the health system. We also argue that this can be improved by achieving health system interoperability, but in the absence of interoperability we commend IHACPA for starting this important work.

Mental health care

The AMA continues to have concerns about using activity-based funding to fund community mental health care. Mental health community organisations currently struggle to provide adequate support and care for all those who need it. This results in the growing reliance of mental health patients on public hospitals and public hospital emergency departments to access the care that they need that cannot be accessed in the community.

The AMA Public Hospital Report Card – Mental Health Edition 2022 showed that the number of ED presentations per 10,000 population nationally almost doubled since 2004-05, from 69.2 to 120.6 per 10,000 people. Along with the increased number of presentations, the severity of illness of the mental health patients presenting to EDs is increasing. Specifically, since 2004, the number of patients presenting at EDs who are triaged as resuscitation has grown from 0.6 per 10,000 population in 2003-04 to 1.7 in 2020-21. That is a 12.3 per cent average annual increase over the five years since 2016-17.[2]

While we acknowledge that reasons for this increase may be multifaceted, and that we do not know how many of those presentations are repeated ones by the same patients (AMA members inform us that many of the mental health patients are), this growing reliance on EDs is indicative of inadequate access to community care.

The AMA understands the need for greater transparency of funding, but we continue to argue that efficiency cannot be the only guideline applied when transitioning to ABF in community mental health care. Efficiency needs to be considered in a broader context of the value that community mental health services provide to those utilising the service, and in the context of the overburdened public hospital services. Mental health care is complex and mental health

[2] https://www.ama.com.au/clear-the-hospital-logjam/phrc

care in the community should be adequately compensated for the complexity of care it provides.

Setting the national efficient price

Impact of COVID-19 and review of COVID-19 Response – Costing and Pricing guidelines

The Pricing Framework consultation paper states that IHACPA intends to review the temporary pricing measures outlined in the COVID-19 Response – Costing and Pricing Guidelines: the COVID-19 treatment adjustment, applicability of the ICU loading to patients with a COVID-19 diagnosis and the hospital acquired complications (HAC) adjustment and the avoidable hospital readmissions (AHR) adjustment not being applied to activity with a COVID-19 diagnosis.

The AMA strongly opposes any proposal to abolish the COVID-19 treatment adjustment in the 2024-25 NEP determination. This is a shocking proposal that will have significant and lasting impact on the health and medical workforce and ultimately sustainability of our public hospitals.

COVID-19 still poses significant individual health and health system risk, and while most public health measures have been removed for the Australian community, mitigation strategies remain in place for medical and other health staff that work in our public hospitals.

The recent Victorian Health Department data published by the media under the freedom of information laws showed that 5614 people were suspected to have caught COVID while in the state's public hospitals between 2020 and April 2023, and that at least 659 of them died.[3] Of the 5,614 estimated hospital acquired COVID infections in total, around 600 occurred in the first four months of 2023 – up to 19 April 2023. That is more than in 2020 and 2021 combined. If this rate continues as we are going through winter months, we are likely to have over 2,000 hospital acquired infections by the end of the year in Victoria alone.

International research has demonstrated that reliance on non-permanent staff, replacement nurses, and overtime hours are significantly associated with increased HAC levels.[4] Further evidence is available that demonstrates the optimal way of preventing HACs is ensuring that sufficient staff are available to provide care, as well as ensuring proper training and education is provided for staff.[5] In Australia's public hospitals we are seeing medical staff, particularly medical trainees, are increasingly working overtime to meet the need created by COVID-19. As a result, they are frequently getting infected themselves, resulting in more staff taking prolonged leave. Additionally, due to COVID-19 much of their training has been moved online, which, while it has been beneficial to some, often results in less time spent with their mentors or requires mentors to rearrange their work practices.

To abolish the COVID-19 treatment adjustment and temporary ICU measure for COVID-19 patients will mean less funding going towards infection prevention in hospitals, less funding for staff rostering and will result in increased infection rates for both patients and staff. This will be

[3] https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2747253/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8898089/#bib0009

happening in parallel with hospitals being penalised for preventing hospital acquired infections from happening. The AMA therefore fervently opposes it.

Plan to assess the impact of COVID-19 on NEP24

The 2024-25 Pricing Framework consultation paper states that IHACPA intends to monitor the backlog of elective surgery and other deferred care to understand the impacts of these changes on activity and cost data. The AMA supports this approach, as we supported it in the 2023-24 Framework. We argued then and we continue to argue that the delay in elective surgeries as the direct result of COVID-19 pandemic is already resulting in more complex surgeries and post-surgical recovery care needs for patients who were affected by the delays. This cost must be factored into any future pricing model.

Furthermore, we continue to call on IHACPA to consider factoring in the cost of delayed access to specialists in the outpatient clinics in the same manner as it is considering factoring in the costs of delayed surgery in the pricing model. Delayed access to a specialist often results in delayed access to elective surgery, leading to patients presenting at emergency departments, having more complex health conditions, later diagnosis of serious illnesses like cancer, and requiring longer recovery.

NEP indexation methodology

In our submission to the 2023-24 Pricing Framework consultation the AMA argued that when setting the 2023 NEP, IHACPA should consider the high inflation rate, cost pressures stemming from higher commodity prices and prices of utility services, as well as limits to procurement of essential tools and diagnostic agents due to international circumstances.[6] While some of the procurement issues have been resolved, we are still witnessing hospital cost increases. Private Healthcare Australia has indicated that "rising costs of recruitment, power and food have hit (private) hospitals hard" with inflation affecting the increase in cost of healthcare.[7]

In the US, hospital labour costs grew 25 percent between 2019 and 2022.[8] Also, in 2022 the OECD acknowledged that external inflationary pressures have a significant impact on the operation of the health systems across the OECD countries. It estimated that even for zero real (adjusted for headline inflation) health spending growth, nominal health spending growth would need to reach 8.8% on average to match the peak in inflation.[9]

In Australia, the projected labour shortages combined with the impact of the palpable and widely recognised burnout of the health staff (resulting in many of them opting for flexible part time work arrangements) as well as staff COVID infections and prolonged sick leave, are the primary underlying drivers of cost growth and they are inevitably going to impact the increase in healthcare costs over the coming years.

[6] https://www.ama.com.au/articles/2023-24-public-hospital-pricing-framework
[7] https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-easing-cost-of-living-pressure/
[8] https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector
[9] https://www.oecd.org/health/Health-care-financing-in-times-of-high-inflation.pdf

All of this will only add to the plight of public hospitals — first and foremost the hospital staff and patients — already struggling due to low indexation of NEP since 2016-17. The AMA has previously identified savings of $34.2 billion over four years to 2019-20, as the result of both low indexation and the 6.5 per cent growth cap.[10]

Combined with poor indexation of the MBS (which we acknowledge is outside of IHACPA's remit), this results in growing pressures on public hospitals, particularly their emergency departments.

The AMA was astounded that for 2023-24 NEP Determination IHACPA decided to index it at a rate of 2.9 per cent per annum, plus an additional 0.81 per cent to account for increases in the minimum superannuation guarantee between 2020–21 and 2023–24. The 2.9 per cent indexation effectively means an annual NEP increase of slightly above $200.[11] In an environment with significant cost pressures, in the AMA view this is substantially below of what is needed.

The *2019 Fundamental Review of the National Efficient Price* commissioned by IHACPA concluded that changes in wage cost/material cost are one of the key drivers of change in costs per episode of care over time, that could be measured through appropriate inflation indices.[12] The review suggested that these could be offset by changes in efficiency and models of care, "resulting in a lower indexation rate that would be indicated by price inflation alone." We understand that this is an approach that IHACPA has decided to take going forward.

However, this review was done prior to COVID-19 which has had an enormous impact on our health services, first and foremost on Australia's public hospitals. For over three years now COVID-19 has been anything but conducive to changes in efficiency and models of care. Furthermore, lack of access to adequate healthcare during the pandemic for older people and people living with chronic conditions, including people suffering from poor mental health, has resulted in increasing pressures on public hospitals, primarily their emergency departments. As a result, public hospitals are currently struggling to barely manage their daily workflows, let alone being able to introduce innovation and additional efficiencies. Moreover, the 2019 review was done in a low inflationary environment that Australia has had for many years prior. With the obvious reluctance to apply appropriate indexation, the AMA suggests that re-baselining the NEP in light of the unparalleled and unexpected effects of the pandemic should be considered.

In the absence of wider health system reform that should ease the pressure on public hospitals (notwithstanding the latest Government policy of Urgent Care Centres that have yet to demonstrate contributing to easing of pressure on public hospital emergency departments) and any changes to the National Health Reform Agreement that are not expected before 2025, the AMA urges IHACPA to index the 2024-25 NEP appropriately.

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[10] https://www.ama.com.au/sites/default/files/2022-10/Public%20hospitals%20-%20cycle%20of%20crisis.pdf
[11] https://www.ihacpa.gov.au/sites/default/files/2023-03/Understanding%20the%20NEP%20and%20NEC%20Determinations%202023-24.PDF
[12] https://www.ihacpa.gov.au/sites/default/files/2022-02/Fundamental%20Review%20of%20the%20NEP%20-%20PwC%20Recommendations%20Report.pdf